TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member Name:_____ DOB: _____ SS#_____
Diagnosis: _____
_____

Recommended level of Care:
☐ Nursing facility level of care ☐ Hospital level of care
☐ Level of care required in an Intermediate Care Facility for MR (ICF-MR)

Medical History: (May attach hospital discharge summary or provide narrative):
_____
_____
_____

Current Needs

	None	Description of Skilled Nursing Needs
Cardiovascular:	____	_____
Neurological:	____	_____
Respiratory:	____	_____
Nutrition:	____	_____
Integumentary:	____	_____
Urogenital:	____	_____
Bowel:	____	_____
Endocrine :	____	_____
Immune:	____	_____
Skeletal:	____	_____
Other:	____	_____

Therapy: Speech sessions/wk ____ PT sessions/wk ____ OT sessions/wk ____ (*attach current notes)*

Hospitalizations within last 12 months: (Attach most recent hospital discharge summary)
Date: _____ Reason: _____ Duration: _____
Comments: _____
_____

Child in school: _____ Hrs per day _____ Days per wk ___ N/A ____ IEP/IFSP __ *(attach if in effect)*
Nurse in attendance during school day: _____ N/A ____*(attach last month's nursing notes)*

Skilled Nursing hours received: Hrs./day _____ N/A _____
I attest that the above information is accurate and this member meets Pediatric Level of Care Criteria and requires the skilled care that is ordinarily provided in a nursing facility, hospital or facililty whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions.

Physician's Signature: _____ Date: _____
Primary Caregiver Signature: _____ Date: _____

**** Foster Care Applicants must have the signature of the DFCS representative.**